STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piney Forest Health and Rehabilitation Center	450 Piney Forest Rd Danville, VA 24540

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure a resident representative was promptly notified of a change in condition resulting in a transfer to the emergency department for one (1) of 23 sampled residents (Resident #35). The findings include: The facility staff failed to promptly notify Resident #35's resident representative of the need to transfer the resident to the emergency department. Resident #35's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/8/25, was signed as completed on 1/13/25. Resident #35 was assessed as able to make self understood and as able to understand others. Resident #35's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. On 12/21/24 at 11:06 p.m., Resident #35 was documented as complaining of a burning sensation when urinating and requesting to be sent to the emergency department. Resident #35 was documented as being sent to the emergency department at 11:51 p.m. No documentation was found to indicate Resident #35's resident representative was notified when the resident was sent to the emergency department on 12/21/24. Resident #35's clinical documentation indicated the resident's representative was notified of the transfer to the emergency department on 12/22/24 at 6:40 a.m.; this was after the facility staff had been notified by the emergency department staff that the resident was being discharged back to the facility. The following information was found in a facility policy titled Significant Change in Condition (with an effective date of 1/29/24): Responsible party will be notified of a change in condition. On 1/30/25 at 9:46 a.m., the Administrator provided documentation of an action plan/plan of correction that addressed the failure of facility staff to promptly notify Resident #35's representative of the resident's transfer to the emergency department. This action plan included the following: - A discussion of the findings of a delay in notifying Resident #35's representative of the resident being sent to the emergency department. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Staff education was provided to address this issue with Resident #35 and to address the potential of this issue impacting other residents. The nurse caring for Resident #35 on the evening of 12/21/24 was provided education. Staff education included the topic of responsible party notification and documentation of a resident's change in condition. - The results of this action plan are scheduled to be discussed during the facility's February/March 2025 Quality Assurance meeting. - The education was completed by 1/10/25. The Administrator reported this was the date the corrective action was completed. The survey team met with the facility's Administrator, Director of Nursing, Assistant Administrator, Regional Nurse Consultant, and [NAME] President of Operations on 1/30/25 at 2:28 p.m. During this meeting, the delay in notifying Resident #35's representative of the 12/21/24 transfer to an emergency department was discussed. This is a past non-compliance deficiency.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review the facility staff failed to ensure an accurate minimum data set assessment (MDS) for 2 of 23 residents, Resident #68 and Resident #98. The findings included: 1. For Resident #68 the facility staff coded the MDS as the resident receiving an anticoagulant, when the resident was not receiving an anticoagulant. Resident #68's face sheet listed diagnoses which included but not limited to peripheral vascular disease. Resident #68's most recent MDS with an assessment reference date of 01/16/25 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that that the resident is moderately cognitively impaired. Section N, medications, subsection N0415, High-Risk Drug Classes, coded the resident as receiving an anticoagulant. Resident #68's comprehensive care plan was reviewed and contained a care plan for ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising and complications due to antiplatelet use secondary to: PVD (peripheral vascular disease). Resident #68's clinical record was reviewed and contained a physician's order summary which read in part, Aspirin EC (enteric coated) Tablet Delayed Release 81 mg (Aspirin). Give 1 tablet by mouth one time a day related to P ERIPHERAL VASCULAR DISEASE, UNSPECIFIED and Clopidogrel Bisulfate Tablet 75 mg. Give 1 tablet by mouth one time a day related to PERIPHERAL VASCULAR DISEASE, UNSPECIFIED. Surveyor could not locate any anticoagulant medication listed on the resident's physician's order summary. Per the Resident Assessment Instrument manual, Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant. Surveyor spoke with the regional MDS coordinator on 01/30/25 at 11:20 am regarding Resident #68's MDS assessment. Regional MDS coordinator stated that neither aspirin nor clopidogrel should be coded as an anticoagulant on Resident #68's assessment. The concern of the incorrect coding of Resident #68's MDS was discussed with the administrator, director of nursing, regional nurse consultant, regional MDS coordinator, and administrator in training on 01/30/25 at 2:30 pm. No further information was provided prior to exit. 2. For Resident #93 the facility staff failed to code the resident as receiving an antidepressant medication on the quarterly MDS (minimum data set) assessment dated [DATE]. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Bipolar Disorder, Type 2 (two) Diabetes Mellitus, Atrial Fibrillation, Cardiogenic Shock, Congestive Heart Failure, Major Depressive Disorder, Parkinson's Disease, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/16/25 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Section N (Medications) was not coded for Antidepressant medications and was left blank (unchecked). A review of Resident #93's medical provider orders included an order dated 11/1/24, that read in part, . Mirtazapine Tablet 30 MG (milligrams) Give 1 (one) tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER . A review of the January 2025 MAR (medication administration record) revealed Resident #93 was receiving the medication, Mirtazapine as ordered. On 1/30/25 at 11:48 AM, surveyor interviewed regional director of MDS, and she reviewed the MDS dated [DATE] and the January 2025 MAR for Resident #93 and agreed Section N should have been coded to reflect the resident was receiving the antidepressant medication. This concern was discussed on 1/30/25 at 2:27 PM during the pre-exit meeting with the administrator, regional director of clinical services, vice president of operations, and administrator-in-training. No further information regarding this concern was presented to the survey team prior to the exit conference on 1/30/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to ensure a wander bracelet was in place for 1 of 23 current sampled residents, Resident #93. The findings included: For Resident #93 the facility staff failed to implement a person-centered intervention to ensure a wander bracelet (a wearable device that helps monitor patients or residents who are at risk of wandering. Wander bracelets are used in healthcare facilities to keep patients safe and can trigger alarms, lock doors, and alert staff) was in place on resident's right ankle to reduce the individual's risk for elopement. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Bipolar Disorder, Type 2 (two) Diabetes Mellitus, Atrial Fibrillation, Cardiogenic Shock, Congestive Heart Failure, Major Depressive Disorder, Parkinson's Disease, and Anxiety Disorder. The most recent MDS (minimum data set) with an assessment reference date (ARD) of 1/16/25 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Review of Section P (Restraints and Alarms) section E. Wander/elopement was coded as 2 (used daily), indicating the wander bracelet was used daily on Resident #93. On 1/30/25 at 10:42 AM, surveyor observed Resident #93 sitting in the lobby and asked other staff #2 (OS#2) for assistance in checking placement of a wander bracelet on resident's right ankle. OS#2 pulled down residents right and left socks and agreed no wander bracelet was visible on Resident #93. OS#2 checked resident's purse straps and wrists, and no wander bracelet was visible on the resident or her purse. Other staff #1 (OS#1) was also present in the lobby and stated, We will get her one. A review of the medical providers orders revealed an order dated 1/21/25 that read in part, .Check function of wander bracelet weekly every day shift .for wandering prevention .Check Wander Prevention patient Band every shift-right ankle every day and night shift for wandering . A review of the clinical record revealed an Elopement Risk Tool dated 11/2/2024, that read in part, .E. 2. Has history of elopement/exit seeking .Scoring .10 .High Risk for elopement/exit seeking . A review of the comprehensive person-centered care plan revealed a focus and interventions that read in part, .the resident is at risk for elopement .check function weekly .check placement every shift .replace elopement band as needed .wanderguard-right ankle . On 1/30/25 at 10:57 AM, surveyor spoke with OS#1, and she stated the nurse put a wander bracelet on Resident #93. On 1/30/25 at 11:06 AM, surveyor spoke with licensed practical nurse # 3 (LPN#3) and she stated wander guards are checked each shift, and she had not checked it (Resident #93's wander bracelet) this shift yet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/30/25 at 11:36 AM, surveyor observed Resident #93 in the hallway and the wander bracelet was noted to be present on resident's right ankle. This concern was discussed on 1/30/25 at 2:27 PM during the pre-exit meeting with the administrator, regional director of clinical services, vice president of operations, and administrator-in-training. Surveyor requested and received a facility policy titled, Elopement/Exit-Seeking Behaviors with an effective date of 1/29/24, that read in part, .2. If a patient is determined to be at risk of elopement/exit-seeking, an intervention using a safety/security system (Wander Guard .) .will be assessed for appropriateness . No further information regarding this concern was presented to the survey team prior to the exit conference on 1/30/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility document review, the facility staff failed to store food in accordance with professional standards for food service safety. The findings included: The facility staff failed to label and date food items in the facility coolers. On 1/28/25 at 1:28 PM this surveyor and the dining services manager entered the walk-in cooler. This surveyor noted a white storage container on the shelf of the cooler and asked the dining services manager what was in it. The dining services manager pulled the container off the shelf. The bottom of the container had a clear fluid in it. There was a cut cucumber wrapped in plastic wrap, a storage bag with cut up onions, several slices of sandwich cheese wrapped in plastic wrap, a storage bag with what looked like lunchmeat and more lunchmeat wrapped in plastic wrap. Each item was saturated with the clear fluid that was in the bottom of the container. None of the items had labels or dates on them. The dining service manager stated the meat in the storage bag was ham and the the meat in the plastic wrap was turkey. The dining service manager stated that the clear fluid was from the lunchmeat and that the other items should have been stored separately. This surveyor asked if the the items should be labeled and dated, they stated, Yes, each item should be labeled and dated. The ham was just opened in the last day or so. It comes in frozen. They showed this surveyor an unopened package of ham that was thawing. The package had a date of November 21, 2024. They stated that the opened package was from the same box as the unopened package and would have had the same date, but they were unable to state with certainty how long the ham had been opened or how long it had been thawing. They stated, I'll throw it all in the trash. In the reach in/prep cooler, there were nine (9) pitchers of juice. The dining service manager identified 4 as being cranberry juice, 4 as being orange juice and 1 as being apple juice. None of the pitchers were labeled or dated. When asked if the pitchers should be labeled/dated she stated, Yes, each one should have a label with a date on it. We will pour them out. This surveyor asked for and received the policy entitled, Food Storage: Cold with a revision date of October 2019 that read in part, It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code. And under the heading, Action Steps 5. The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. On 1/29/25 at 5:00 PM the survey team met with the Administrator, Director of Nursing, Nurse Consultant, and the Administrator in Training. This concern was reviewed with them at that time. No further information was presented to the survey team prior to the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews and clinical record review, the facility staff failed to maintain complete and/or accurate clinical records for one (1) of 23 residents (Resident #20). The findings include: The facility staff failed to ensure that Resident #20's Medication Administration Records (MARs) accurately captured the resident's behaviors. Resident #20's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/3/25, was signed as completed on 1/8/25. Resident #20 was assessed as able to make self understood and as able to understand others. Resident #20's Brief Interview for Mental Status (BIMS) summary score was documented as six (6) out of 15; this indicated severe cognitive impairment. Resident #20's MARs for October 2024, November 2024, and January 2025 included an area for facility staff to document monitored behaviors. These MARs included places for behavior monitoring to be documented twice a day (once for dayshift and once for nightshift). The instructions were for a Y to be documented if behaviors were observed and N to be documented if no behaviors were observed; if behaviors were observed the findings were to be documented in the progress notes. Resident #20's MARs for October 2024, November 2024, and January 2025 did not have a Y or N documented for the behavior monitoring. A checkmark was documented instead of a Y or N. No instructions were provided to indicate what a checkmark meant. On 1/30/25 at 12:14 p.m., the Regional Nurse Consultant (RNC) reported a checkmark indicated the resident was assessed and found to not have exhibited the behaviors monitored. Review of the aforementioned MARs indicated the facility staff consistently documented checkmarks for behavior monitoring. Resident #20's progress notes included evidence of the following behaviors documented for 10/19/24 at 7:01 a.m.: yelling, refusing medications, and throwing medications on the floor. These behaviors were not captured on the MAR. Resident #20's progress notes included evidence of the following behaviors documented for 10/25/24 at 12:17 p.m.: yelling, screaming, and cussing. These behaviors were not captured on the MAR. Resident #20's provider progress notes included the following documentation of behaviors documented for 10/27/24 at 11:00 p.m.: The patient is seen today again at the request of nursing for evaluation of her behaviors. The patient has again been throwing things at staff, crying, yelling . These behaviors were not captured on the MAR. Resident #20's progress notes included evidence of the resident refusing medications on 11/11/24 at 8:58 a. m. This behavior was not captured on the MAR. The survey team met with the facility's Administrator, Director of Nursing, Assistant Administrator, Regional Nurse Consultant, and [NAME] President of Operations on 1/30/25 at 2:28 p.m. During this meeting, Resident #20's MAR documentation not correctly capturing the resident's behaviors was discussed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, clinical record review, and facility document review, the facility staff failed to: (a) follow infection control guidelines to decrease the potential of and/or risk for infection transmission for 19 residents experiencing gastroenteritis with nausea, vomiting, and/or diarrhea; (b) utilize the appropriate personal protective equipment (PPE) for one (1) of 23 sampled residents (Resident #107); and (c) implement infection prevention and control procedures/processes for ESBL (extended-spectrum beta-lactamase) urine infection for one (1) of 23 sampled residents (Resident #93). The findings include: 1. The facility staff failed to promptly implement contact isolation for 19 residents identified as having gastroenteritis. (Gastroenteritis is often an infectious process resulting in nausea, vomiting, and/or diarrhea.) On the afternoon of 1/28/25, shortly after entering the facility, the facility staff notified the survey team of having several patients and staff members experiencing nausea, vomiting, and/or diarrhea. On 1/28/24, at approximately 2:30 p.m., it was noted that residents who were reported to have gastroenteritis symptoms were not on contact isolation. On 1/28/25 at 2:30 p.m., the facility's Infection Preventionist (IP) provided the surveyor with a list of 19 residents who were experiencing gastroenteritis symptoms; 10 of the 19 residents were documented on the facility's line-list to have had gastroenteritis symptoms start on 1/27/25. The IP and the surveyor toured the facility to make observations of the rooms where the 19 residents with gastroenteritis symptoms resided; none of these rooms were noted to have contact isolation signs posted to notify staff and visitors of the need to use the necessary personal protective equipment (PPE). The IP showed the surveyor a copy of a Contact Isolation sign that should have been posted for the 19 residents with gastroenteritis symptoms. The following information was found in a facility policy titled Infection Outbreak Standards of Practice (with an effective date of 2/6/2020): Measures are to be taken to limit the further spread of the outbreak . The following information was found in a facility policy titled Standard of Practice in the Norovirus section of the facility's policies (with an effective date of 2/6/2020): - POLICY . To establish standards of practice and education that provides parameters for appropriate clinical management and follow-up of patients and employees known or suspected to have norovirus. - An outbreak is defined as the presence of more diarrheas or vomiting [sic] than would usually be expected in the Center, or on a particular unit, for that time of year. A basic threshold for norovirus might be three or more cases of illness among patients and/or employees within a 72-hour period. - Special contact precautions in addition to standard precautions are indicated when caring for persons with norovirus. Change gowns and gloves between contacts with roommates. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following information was found in a facility policy titled Transmission Based Precaution - General Practice (with an effective date of 12/1/21): - The Center initiates transmission-based precautions (TBPs) to protect other patients, employees and visitors from the spread of a confirmed or suspected infection or contagious disease. The TBPs will be based on the type of pathogens, knowledge of the natural history of certain diseases and studies of epidemiology. The TBP measures will be the least restrictive possible for the patient under the circumstances. - The type of TBPs instituted will be based on studies of pathogens, knowledge of the natural history of certain diseases, and studies of epidemiology. - An appropriate isolation precaution card will be placed on the patient's door. On the afternoon of 1/28/25 at 5:30 p.m., the 19 residents who were reported to have been experiencing nausea, vomiting, and/or diarrhea were noted to have contact isolation signs posted outside their rooms. These signs indicated: (a) hand hygiene was required before entering and before exiting the room, (b) gowns should be worn when entering the room, and (c) gloves should be worn when entering the room. On 1/29/25 at 3:31 p.m., Registered Nurse (RN) #2 was observed to be providing care for Resident #107 without wearing a gown. (On the morning of 10/29/25 at 10:05 a.m., Resident #107 was documented as experiencing nausea and vomiting resulting in the nurse practitioner (NP) ordering medications and intravenous (IV) fluids.) Resident #107's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/6/25, was signed as completed on 1/10/25. Resident #107 was assessed as able to make self understood and as able to understand others. Resident #107's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. On 1/29/25 at 3:34 p.m., the Infection Preventionist (IP) was asked to observe RN #2 providing care for Resident #107. The IP confirmed RN #2 should have been wearing a gown while providing care for the resident. ON 1/29/25 at 3:37 p.m., RN #2 was interviewed about the care she was providing for Resident #107. RN #2 stated she was providing IV fluids. RN #2 reported she should have been wearing a gown. The survey team met with the facility's Administrator, Director of Nursing, Assistant Administrator, Regional Nurse Consultant, and [NAME] President of Operations on 1/30/25 at 2:28 p.m. During this meeting, the failure of the facility staff to correctly implement contact isolation precautions was discussed. 2. For Resident #93 the facility staff failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infection by failing to identify the need for transmission based precautions for the resident due to an active infection of ESBL (extended-spectrum beta-lactamase, which is an enzyme that makes bacteria resistant to many antibiotics. Infections caused by ESBL-producing bacteria can be difficult to treat.) in the resident's urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Bipolar Disorder, Type 2 (two) Diabetes Mellitus, Atrial Fibrillation, Cardiogenic Shock, Congestive Heart Failure, Major Depressive Disorder, Parkinson's Disease, and Anxiety Disorder. The most recent MDS (minimum data set) with an assessment reference date (ARD) of 1/16/25 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. On 1/28/25 at 4:56 PM, surveyor observed a contact isolation sign outside of Resident #93's room, located on the wall beside her door. A review of Resident #93's medical provider orders included an order with a start date of 1/24/25, that read in part, .Ertapenem Sodium Injection Solution .Inject 1 (one) gram intramuscularly one time a day for UTI (urinary tract infection) for 5 (five) days . Review of the medical providers orders also revealed an order with a start date of 1/28/25, that read in part, . Contact Precautions every shift until 01/31/2025 . A review of the clinical record revealed the following: A progress note dated 1/21/2025 read in part, Health Status Note .Note Text : UA C&S (urine analysis & urine culture and sensitivity-a test that examines a urine sample for signs of infection, inflammation, or other abnormalities) urinalysis collected via urine hat (a disposable collection device that fits over the rim of a toilet to collect urine samples). A medical provider progress note dated 1/24/25, read in part, .patient is seen today for evaluation of UTI (urinary tract infection) .urine did return positive for infection .specifically E. coli (escherichia coli, which is a type of bacteria) ESBL . A review of the comprehensive person-centered care plan had a focus and interventions that read in part, . ISOLATION/PRECAUTIONS: the resident required contact isolation/precautions related to urinary tract infection-ESBL Created on: 01/29/2025 . isolation precautions per order . On 1/30/25 at 10:39 AM, surveyor interviewed Infection Preventionist (IP), and she stated she was not aware of Resident #93 being positive for ESBL until Monday, January 27, 2025. IP stated she was working on 1/24/25 but was not aware of the results of the urine analysis. The IP did agree that the nurse's should know to place residents with ESBL infections on contact precautions whether she is available in the building or not. IP agreed Resident #93 should have been placed on contact precautions on 1/24/25. This concern was discussed on 1/30/25 at 2:27 PM during the pre-exit meeting with the administrator, regional director of clinical services, vice president of operations, and administrator-in-training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Piney Forest Health and Rehabilitation Center	450 Piney Forest Rd Danville, VA 24540

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received a facility policy titled, Extended Spectrum Beta-Lactamase with an effective date of 2/6/2020 that read in part, .The Center establishes standards of practice and provides parameters for appropriate clinical management and education of patients known or suspected to have an extended spectrum beta-lactamase (ESBL) producing organism present .5. Transmission a. Direct contact with infective secretions/excretions. b. Via contaminated hands of healthcare providers .6. Transmission Prevention .b. Contact precautions in addition to standard precautions in accordance with physician orders and patient's condition. i. Follow contact precaution instructions .7. Management and Treatment a. Prompt identification and physician notification of the presence of an ESBL organism .d. Place on contact precautions per physician orders . No further information regarding this concern was presented to the survey team prior to the exit conference on 1/30/25.